OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

July 30, 2019

MEMORANDUM FOR: Waldemar Rodriguez
Associate Director
Office of Professional Responsibility
U.S. Immigration and Customs Enforcement

FROM: (b) (6), (b) (7)(C)
Assistant Special Agent in Charge
Office of Investigations
Atlanta Field Office

SUBJECT: (b) (6), (b) (7)
(b) (6), (b) (7)(C)
U.S. Immigration and Customs Enforcement
Lumpkin, GA

CASE NUMBER: I17-ICE-ATL-15215

Attached is our Report of Investigation (ROI) on the above subject.

The ROI is furnished to you to evaluate and make an administrative decision regarding the above listed subject. Should you take any administrative action in response to our ROI, please inform this office so we can update our records. Please destroy the ROI upon disposition of this matter.

Should you have any questions regarding the contents of the ROI or need additional information, you may contact me at 404-832-(b) .

Attachment

DEPARTMENT OF HOMELAND SECURITY
OFFICE OF INSPECTOR GENERAL

REPORT OF INVESTIGATION

I17-ICE-ATL-15215

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

REPORT OF INVESTIGATION

Case Number:	I17-ICE-ATL-15215
Case Title:	(b) (6), (b) (b) (6), (b) (7)(C) U.S. Immigration and Customs Enforcement Lumpkin, GA
Report Status:	Final
Alleged Violation(s):	Title 18 U.S. Code § 1001 (False Statements, Entries or Concealing or Covering Up a Material Fact)

SYNOPSIS

The Department of Homeland Security (DHS), Office of Inspector General (OIG) initiated an investigation based upon information received from U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), who advised of the death of Jean Carlos Jimenez-Joseph, Detainee, Stewart Detention Center (SDC) Lumpkin, GA. SDC is a privately operated detention facility managed by CoreCivic with oversight from ICE.

Pursuant to state of Georgia protocol, the Georgia Bureau of Investigation (GBI) conducted the cell processing and death investigation and the Stewart County Medical Examiner (SCME) conducted the autopsy. The SCME determined that the manner of death was suicide, which was caused by hanging. Pursuant to ICE procedure, a Mortality Review was conducted by ICE Health Service Corps (IHSC), followed by a Detainee Death Review by the External Reviews and Analysis Unit (ERAU), ICE.

The DHS OIG reviewed the incident and learned through investigative interviews that a falsification of documents had allegedly occurred at SDC relating to the events surrounding the incident. The DHS OIG interviewed and obtained a confession from (b) (6), (b) (7)(C) CoreCivic, SDC, Lumpkin, GA, in which (b) admitted falsifying documents regarding a required

Reporting Agent		(b) (6), (b) (7)(C)	*Distribution:*	
Name: (b) (6), (b)	Signatur		Atlanta FO	Original
Title: Special Agent	Date:			
			Headquarters	cc
Approving Official				
Name: (b) (6),	Signatur		Component(s)	cc
Title: Acting Special Agent in Charge	Date:			
			Other	cc

INV FORM-08

detainee observation "round count." According to ICE policy 10-100, Performance-Based National Detention Standards (PBNDS), SDC corrections officers are required to conduct round counts of detainees housed in Special Management Units, such as the specialized observational unit in which Jimenez-Joseph was housed, and document that the round counts occurred. (b) admitted he falsified a required detainee observational round count document, in which he recorded that a round count had occurred, when it had not. Jimenez-Joseph attributed the "missed" round count to inadequate staffing at SDC.

(b) was terminated from employment with CoreCivic due to the falsely certified document. The (b) investigation was referred to the United States Attorney's Office (USAO), Middle District of Georgia, Columbus, GA, which declined to prosecute the matter criminally due the totality of factors and events leading up to the suicide of Jimenez-Joseph.

The Mortality Review by IHSC and Detainee Death Review by ERAU was conducted which analyzed the detainee's prior mental health diagnosis and previous suicide attempts; custodial oversight and medical treatment of Jimenez-Joseph while in ICE custody; applicable ICE policies and recommendations of procedural changes were made by ISHC and ERAU.

DETAILS

The DHS OIG initiated an investigation on May 17, 2017, upon receipt of information from the U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR) that the Georgia Bureau of Investigation (GBI) responded to the Stewart Detention Center (SDC), Lumpkin, GA, to investigate the apparent suicide of detainee Jean Carlos Jimenez-Joseph. (Exhibit 1)

Allegation: Review of the circumstances surrounding the apparent suicide of ICE detainee Jean Carlos-Jimenez-Joseph.

Pursuant to standard protocol in the state of Georgia, the GBI processed the cell and conducted an investigation into the incident. The DHS OIG contacted (b) (6), (b) (7)(C), Special Agent (SA), GBI, Americus, GA, who was assigned to investigate the circumstances surrounding the death of Jimenez-Joseph. (b) (6), (b) advised that on May 15, 2017, he was assigned to respond to an apparent suicide at SDC. Upon arrival at SDC, (b) (6), (b) interviewed (b) (6), (b) (7)(C) SDC, Lumpkin, GA, and (b) (6), (b) (7)(C), SDC, Lumpkin, GA. (b) (6), (b) (7)(C) advised that Jimenez-Joseph reported to SDC on March 7, 2017 and that the incident occurred in a specialized detention unit of SDC. The GBI learned that on April 27, 2017, Jimenez-Joseph was placed in a segregation cell for 20 days due to Jimenez-Joseph jumping off a 2nd floor walkway down to the 1st floor. On May 2, 2017, Jimenez-Joseph received three additional days in confinement for exposing his penis to a SDC nursing staff member. It was determined that Jimenez-Joseph was housed in a Segregation/Restrictive Housing unit at the time of his death.

(b) (6), (b) provided video surveillance footage, SDC handheld video response footage, miscellaneous cell surveillance footage, recorded telephone calls and GBI investigative documents to DHS OIG. A review of the material provided yielded that on May 15, 2017, at approximately 12:45 a.m., while conducting a round count, (b) (6), (b) (7)(C), CoreCivic, SDC observed Jimenez-Joseph hanging by his neck from a bed sheet while the other end of the bed sheet was tied to a sprinkler head. Attempts were made to resuscitate Jimenez-Joseph by SDC staff until Stewart County Emergency Medical Technicians (EMT's) arrived which continued efforts to resuscitate Jimenez-Joseph. EMTs transported Jimenez-Joseph to Phoebe Sumter Medical Center (PSMC), Americus, GA, where he was pronounced deceased upon arrival. (Exhibit 2)

(b) (6), (b) interviewed (b) who was the first officer to respond to the apparent suicide. (b) advised that he was assigned to Unit 7A, the unit where Jimenez-Joseph was being housed and a specialized detention unit within SDC. (b) related that it was his responsibility to conduct a round count of detainees housed in that unit every 30 minutes. (b) recalled that on May 15, 2017, at approximately 12:45 a.m., he looked inside cell #102, which was Jimenez-Joseph's assigned cell, and observed Jimenez-Joseph slumped down with a "noose" tied over his neck. (b) indicated he reported a "Medical Emergency" via radio and immediately went to obtain a

"cut-down tool" from the control room. (b) returned and was successfully able to cut the "noose" and lowered Jimenez-Joseph to the ground. (b) advised that both he and (b) , SDC, responded to the emergency call and began CPR until medical staff arrived. The medical staff then took over attempts to revive Jimenez-Joseph until EMT's arrived. The GBI determined that the following SDC officers responded to (b) emergency radio call: (b) (6), (b) (7)(C) . SDC medical staff that responded were (b) (6), (b) (7)(C) , both Registered Nurses (RN). (Exhibit 3)

The GBI conducted an interview of (b) (6), (b) (7)(C) , SDC. (b) (6), advised she was familiar with Jimenez-Joseph and assisted in his care while at SDC. (b) (6), related that Jimenez-Joseph had a suicidal history and underwent treatment for a mood condition by IHSC while at SDC. (b) (6), stated the last time she saw Jimenez-Joseph was on May 10, 2017. (b) (6), related that she documented that Jimenez-Joseph was normal with no suicidal thoughts and recalled Jimenez-Joseph showing her paintings he was working on, but had requested an increase to his prescribed medication. Due to the medication dosage change request by Jimenez-Joseph, a May 15, 2017, appointment was set for Jimenez-Joseph to see (b) (6), (b) (7)(C) , who was authorized to make adjustments to detainee's medications. Jimenez-Joseph committed suicide the day of that appointment. (Exhibit 4)

(b) (6), (b) advised DHS OIG that the GBI had attempted to conduct an interview of Jimenez-Joseph's family members as part of their investigation. The GBI was advised that Andrew Free, Attorney, had been retained by Jimenez-Joseph's family. (b) (6), (b) advised that he conducted a meeting with Free and (b) (6), (b) (7)(C) advised that Jimenez-Joseph acted as if he had multiple personalities and on three separate occasions had been admitted to the Mental Crisis Unit in Wake County, NC. (b) (6), (b) was advised that in March of 2017, (b) (6), (b) (7)(C) stated Jimenez-Joseph told them he was assaulted by an unknown inmate at SDC and wanted to file a police report, but had problems getting the incident reported to the police. Jimenez-Joseph also told them that he was tired of SDC and tried to kill himself by jumping off the 2nd story floor at SDC. (b) (6), (b) (7)(C) indicated that Jimenez-Joseph attempted suicide two known times in the past, one of which involved a rope, and stated they realized Jimenez-Joseph was mentally unbalanced. (Exhibit 5)

The DHS OIG was advised by (b) (6), (b) that the GBI had received the Medical Examiner's (ME) Autopsy Report which was issued by (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) GBI, Decatur, GA. A toxicology report confirmed the presence of Risperidone in Jimenez-Joseph's system, which was the medication Jimenez was prescribed for a mood condition. (b) (6), (b) advised that the autopsy report noted that the injuries to Jimenez-Joseph were consistent with a self-inflicted hanging and the death was ruled a suicide. (b) (6), (b) advised that the GBI investigation

was concluded after completion of witness statements, crime scene processing, surveillance footage and the autopsy conclusion. (Exhibit 6)

The DHS OIG conducted a review of ICE policy and procedures and attended a post-incident meeting conducted by (b) (6), (b) (7)(C), IHSC, SDC. The purpose of the meeting was a "round-table" discussion to review an incident like the Jimenez-Joseph death, discuss any lessons learned and provide applicable training to representatives of both IHSC and ICE, Enforcement and Removal (ERO). DHS OIG requested copies of the documents utilized in the meeting. (b) (6), (b) provided DHS OIG with the Root Cause Analysis Action Plan Feedback and the pre-decisional Mortality Review.

The DHS OIG reviewed the documents received from (b) (6), (b). The following executive summary provided a synopsis of the reports reviewed, due to the medical nature of the report, reference should be made to the full report for additional details:

Executive summary: Mr. Jean Carlos Alfonso JIMENEZ Joseph, a 27-year-old Panamanian male, was in ICE custody from March 2, 2017 to May 15, 2017. Prior to intake into ICE custody, he had a prior history of suicide attempts and psychiatric hospitalizations for psychosis (i.e., a symptom of serious mental disorders characterized by an impaired relationship with reality; psychotic persons may have either hallucinations or delusions), paranoia (a mental condition characterized by delusions of persecution or exaggerated self-importance), schizophrenia (i.e., a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and auditory hallucinations (i.e., hearing internal words or noises that have no real origin in the outside world and are perceived to be separate from the person's mental processes) that were sometimes command in nature (i.e., the contents of the hallucinations can range from innocuous to commands that cause harm to self or others). During the course of his custody, he was treated for psychosis with auditory hallucinations and schizoaffective disorder, bipolar type (i.e., a mental disorder in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). On May 15, 2017, custody officers found Mr. JIMENEZ in his Stewart Detention Center (SDC) special management unit (SMU) cell unresponsive and hanging with a sheet tied around his neck. Subsequent resuscitation efforts were unsuccessful, and he was pronounced dead in a local emergency department.

Mortality finding: Based on the overall findings of this review, Mr. JIMENEZ's progressively deteriorating mental health status warranted timely behavioral health provider (BHP) telephone consultations with a psychiatrist and/or referral to a psychiatrist. Although it is reasonable to consider monitoring a patient with a known mental health disorder in a detention facility, Mr. JIMENEZ's symptoms were becoming progressively worse, his prescribed psychotropic regimen was not at a therapeutic level, and SDC did not have adequate psychiatry resources to appropriately manage Mr. JIMENEZ. Therefore, it would have been best practice to refer Mr. JIMENEZ to an in-patient psychiatric facility or another detention facility with adequate psychiatry

services. Additionally, a detailed summary of additional health care delivery/program weaknesses were identified in the following areas during the review: Medical pre-screening prioritization; Prescribing continuity medications upon intake into SDC; Timely medical intake screening for PRI-1 referral; Suicide Prevention and Intervention; Identification and notification of detainees with serious mental health conditions; Timely access to necessary and appropriate mental health care; Special Management Unit (SMU); Sufficient number of appropriately trained and qualified mental health staff; Communication regarding serious mental illness and special vulnerabilities; Access to emergency medical services. See attached Mortality Review document for specific recommendations made in those areas identified. (Exhibit 7 and 8)

The DHS OIG interviewed (b) (6), (b) (7)(C) ERAU, ICE, OPR, Washington, DC. (b) (6), related that the ERAU process when a detainee death occurs is to conduct an independent review of the incident which is separate from the IHSC review process. (b) (6), explained that IHSC's general focus of review is related to the medical procedures and continuum of care provided to detainees where as ERAU reviews an incident with more of an emphasis on detention and security. (b) (6), advised that the IHSC initiates the pre-decisional Mortality Review which reviews the incident and advises of any recommendations for improvement to be made. (b) (6), further explained that the role of ERAU is to utilize the fact patterns and recommendations contained in the IHSC report and independently create a "Detainee Death Report" which outlines ERAU's findings of the specific incident. In the Jimenez-Joseph death incident, (b) (6), advised that recommendations were made following the review of the incident, which is not atypical given the scope of reviews conducted and provided the Detainee Death Report from ERAU to DHS OIG.

[Agent's Note: Due to the scope of ERAU's review and specificity of the report generated, the ERAU's report is not fully synopsized here. The ERAU report was reviewed along with the IHSC report. No inconsistencies were identified. Reference should be made to those individual reports for additional details and each reviewing components specific recommendations.]

ERAU's Detainee Death Report depicted the following synopsis:

From June 20 to 22, 2017, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited SDC to review the circumstances surrounding JIMENEZ's death. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security. ERAU's contract SMEs are employed by Creative Corrections, a national management and consulting firm. As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to JIMENEZ, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis, and staff from the local ICE Office of Enforcement and Removal Operations (ERO). During the review, the ERAU team took note of any deficiencies observed in the detention standards as they related to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed

to the death of the detainee. ERAU determined the following timeline of events, from the time of JIMENEZ's apprehension by ERO, through his detention at SDC, and eventual death at PSMC. (Exhibit 9)

Allegation #2: A falsification of documentation occurred.

The DHS OIG interviewed (b) (6), (b) (7)(C), CoreCivic, SDC. Documents were provided by (b) (6), (b) (7)(C) which revealed that one employee had been terminated as a result of the Jimenez-Joseph incident. DHS OIG determined that (b) had been terminated for cause after an internal investigation by CoreCivic showed that a round count may have been falsified in CoreCivic's internal round count verification log. DHS OIG determined that a manual entry containing the time and the employee signature is entered onto a log sheet certifying that a round check was completed as required. Shift supervisors then review the log sheets to verify the required round checks were performed. (Exhibit 10)

The DHS OIG interviewed (b) (6), (b) (7)(C), CoreCivic, SDC. (b) confirmed that (b) was terminated during a meeting attended by her, (b) (6), (b) (7)(C) advised a copy of the "CoreCivic Facility Employee Problem Solving Notice" was provided to (b) during the meeting. A review of the document indicated that (b) was issued the notice on May 14, 2017, for Failure to Follow Policy/Procedures and Violating Code of Ethics and Business Conduct. A description of the incident stated:

On the evening of May 14 and 15, 2017, (b) (6), (b) (7)(C) *was assigned to Unit 7A (Restricted Housing Unit) where he failed to make his required 30 minute detainee observation rounds, per CoreCivic policy 10-100 section J Supervisor paragraph 1.* (b) (6), (b) (7) *then falsified document 10-1F, indicating that he made the required observation rounds.* (Exhibit 11)

The DHS OIG interviewed (b) (6), (b) ICE, ERO, SDC. (b) (6), stated that she (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) in February of 2017 to review compliance for inspection items. DHS OIG and (b) (6), reviewed ICE policy labeled 10-100, PBNDS, Special Management Units which stated the following:

In accordance with ICE PBNDS 2.12 Special Management Units, ICE detainees in special management units (SNU) shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly (see Facility policy 9-105 Dry Cell Watches and/or CoreCivic Policy 13-84 Suicide Management).

DHS OIG and (b) (6), also reviewed CoreCivic Facility Policy 10-100 regarding Special Management Residents. Section J, pertaining to the supervision of detainees, stated:

All inmates/residents of segregation, regardless of status, and restrictive housing, will be personally observed by an officer assigned to the unit twice per hour, but no more than forty (40) minutes apart, on an irregular schedule. Observation will be documented in the 10-1F Confinement Watch Log.

Additional language was noted in the CoreCivic policy notating that ICE ERO Policy 10-100, required observation of no more than 30 minutes per round. The DHS OIG determined that the more stringent 30 minute requirement outlined in the ICE ERO policy superseded the 40 minute CoreCivic Policy. (Exhibit 12)

The DHS OIG reviewed SDC video surveillance, a timeline completed by GBI, and the ERAU Detainee Death Review report to review the period of time between 8:30 p.m. on May 14, 2017 and 2:00 a.m. on May 15, 2017, which encompassed the time frame of Jimenez-Joseph's suicide. A synopsis of the timeline of events is as follows: [Agent's note: Reference should be made to the GBI Timeline and ERAU Detainee Death Review report, which provides additional details.]

- 8:59 p.m. on May 14, 2017: (b) (6), encountered Jimenez-Joseph during pill pass to provide his prescribed Risperidone.
- 10:00 p.m.: (b) begins his 10:00 a.m. to 6:00 p.m. shift in Unit 7A.
- 10:14 p.m.: (b) conducts check of Jimenez-Joseph's cell.
- 11:00 p.m.: (b) (6), conducts check of Jimenez-Joseph's cell.
- 11:02 p.m.: (b) conducts check of Jimenez-Joseph's cell.
- 11:26 p.m.: (b) conducts check of Jimenez-Joseph's cell.
- 11:58 p.m.: (b) (6), (b) performs supervisory inspection of Unit 7A.
- 12:43 a.m. on May 15, 2017: (b) discovers Jimenez-Joseph hanging in his cell.

As seen in surveillance footage of Unit 7A, (b) was observed leaving his post without being relieved on six occasions in violation of the SMU post orders that state the unit officer may not leave the post unless properly relieved by another officer. (b) stated during an ERAU interview that he stepped outside the unit on several occasions to call the unit control officer as the intercom system inside the unit did not work. (b) documented seven rounds, with five of them being verified on surveillance video. Of the five verified rounds, one occurred outside the 30-minute timeframe.

ERAU reported that (b) completed three separate incident reports, each dated May 15, 2017. The first report documented his actions after he found Jimenez-Joseph hanging, and his chronology aligns with the events in the surveillance footage. In the second report, (b) documented he made rounds at 12:00 a.m. and 12:28 a.m., neither of which were corroborated by the surveillance video. (b) stated to ERAU that he wrote the two-page incident report first, the second incident report while in the unit, and the third incident report while in the administrative area of SDC.

(Exhibit 13 and 14)

The DHS OIG interviewed (b) who stated he was previously employed at SDC for six years and worked the third shift, 10 p.m. to 6 a.m., during which the death of Jimenez-Joseph occurred. (b) advised he was routinely assigned to the segregation unit and had received special training to work in that unit. (b) recalled leaving unit 7A, which was where Jimenez-Joseph was housed, three times during his shift the night of the Jimenez-Joseph's death; one time to get a detainee clothing, a second time to speak to (b) (6), , which was his shift supervisor, and a third time to take a detainee to Unit 5. (b) was not sure if leaving the unit was against policy, but stated there was one other officer (identified from surveillance footage as (b) (6), (b) (7)(C)) in unit 7A when he left the unit to perform the other needed duties. However, the second officer in the unit was a "one on one officer," which is required to remain outside a detainee's cell for continuous observation and does not assist with other duties or making rounds. (b) advised that he was aware that rounds had to be conducted every 30 minutes; however, he indicated he was trying to cover multiple duties and responsibilities that resulted in his inability to perform all the required rounds.

(b) stated he falsified the required logbook indicating that he had performed the required rounds when in fact he had not. (b) was shown a document previously obtained by DHS OIG labeled Confinement Watch Log, 10-1, and dated May 14, 2017. (b) confirmed that the log was the one he completed the night of the incident and verified that his initials were depicted on the document indicating he performed rounds at "2208, 2236, 2304 and 2332, 0000, 0028 and 0045." (b) admitted to and believed he falsified one of the seven entries notated, but could not be sure which entry was false. (b) stated that he was not ordered by anyone at SDC to falsify the document and stated he was "just trying to cover himself."

(b) indicated that inadequate staffing on his shift led him to falsify the document and, due to multiple other duties he performed the night of the incident, he could not perform the rounds as required. (b) opined that the segregation unit needs four people at all times and the third shift, which was previously his shift, is the only shift that is inadequately staffed. (b) advised he complained to management about the inadequate staffing on his shift and was told that the regulations required only the presence of one person. After the incident, (b) stated he met with (b) (6), (b) (7)(C) and provided a written statement regarding the events of the night of Jimenez-Joseph's death and was subsequently placed on administrative leave pending the investigation. (b) confirmed he was later interviewed by the GBI. (b) advised he then met with (b) (6), and an unknown human resources employee and was terminated at that time. (Exhibit 15)

The DHS OIG interviewed (b) (6), who stated he was an officer at SDC for six years; the last three years as a (b) (6), , three years before as (b) (6), (b) . He confirmed that he worked the third shift, 10 p.m. to 6 a.m., the evening of the Jimenez-Joseph death. (b) (6), was asked if any employee complained about staffing to him on either of his shifts and he stated that no complaints about staffing were brought directly to him. However, (b) (6), explained that there were additional

personnel added after the suicide death of Jimenez-Joseph, and that an additional officer had been added to the third shift. (b) (6), stated that as a supervisor, employees are required to let him know if they need someone to cover them in a unit. (did not recall (b) asking him or telling him he needed to leave the unit to perform any other duties or tasks. However, as a supervisor, (b) (6), is required to walk around and check to make sure staff is present in assigned units once during shifts. (explained that he had to counsel employees before for being away from their posts. (b) (6), advised that all officers are issued radios and can call on the radio if they need additional personnel. On the night of the incident, (b) (6), recalled hearing a call on the radio from (b) advising of the emergency. (b) (6), stated that (b) (6), (b) (7)(C) were on-scene, EMS had been notified and (b) (6), contacted all staff and gave emergency orders. (b) (6), opined that complacency and a lack of staffing were possible contributing factors to the incident. (b) (6), said he checks the log sheets to ensure there are four checks for the assigned period, per SDC policy, but was not aware of any officer falsifying documents or log sheets. (b) (6), was unaware whether anyone was disciplined following the incident. (b) (6), added, at the time of the incident staffing numbers "were way down and after the incident staffing numbers have come up." (b) (6), explained that to work in segregation, 40 hours of specific training is required; however, training is not ongoing. (b) (6), advised that a recently issued policy required him to meet with staff regularly. (Exhibit 16)

The DHS OIG obtained the segregation staffing model provided by CoreCivic which indicated that the first shift (6 a.m. to 2 p.m.) has one employee in the control room and three on the floor; the second shift (2 p.m. to 10 p.m.) has one employee in the control room and two on the floor and the third shift (10 p.m. to 6 a.m.) has one employee in the control room and one on the floor. (Exhibit 17)

The DHS OIG submitted a Prosecution Summary outlying the details of the investigation to (b) (6), , Assistant United States Attorney, Middle District of Georgia. (b) sent the Prosecution (b)(7) Summary to (b) (6), (b) , Criminal Chief, USAO, Middle District of Georgia for additional review and consideration. (Exhibit 18)

The DHS OIG was advised by (b) that the USAO declined to pursue criminal charges against (b) due to the totality of events leading up to the death of Jimenez Joseph. (Exhibit 19)

EXHIBITS

NUMBER	DESCRIPTION
1	Memorandum of Activity, Case Initiation, dated May 17, 2017
2	Memorandum of Activity, Other—Review of GBI Documents , October 25, 2017
3	GBI Interview of (b) (6(b) (6), dated May 15, 2017
4	GBI Interview of (b) (6), (b) (7)(C)ry, dated May 15, 2017
5	GBI Interview of Jimenez Joseph's Family Members, dated May 19, 2017
6	Autopsy Report, dated July 26, 2017
7	IHSC Mortality Review, dated December 15, 2017
8	Root Cause Analysis Action Plan Feedback, signed December 28, 2017
9	ERAU Detainee Death Report, dated June 27, 2019
10	Memorandum of Activity, Records Review—SDC Investigation, dated December 6, 2017
11	Memorandum of Activity, Personal Contact: (b) (6), (b) , dated November 2, 2017
12	Memorandum of Activity, Personal Interview: (b) (6), (b) (7) , dated November 2, 2017
13	GBI Timeline from GBI Investigative Report
14	ERAU Timeline from Detainee Death Review
15	Memorandum of Activity, Personal Interview: (b) (6(b) (6), dated November 2, 2017
16	Memorandum of Activity, Personal Interview: (b) (6), (b) , dated November 2, 2017
17	SDC Staffing Model Information
18	Memorandum of Activity, Other: Prosecution Summary, dated May 25, 2018
19	Memorandum of Activity, Other: USAO Declination, dated March 20, 2019

EXHIBIT #1

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: Case Initiation

Case Number: I17-ICE-ATL-15215	***Case Title:*** FNU, LNU; Lumpkin, GA

On May 17, 2017, the Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta Field Office, was advised by (b) (6), (b) (7)(C), Senior Special Agent (SSA), Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), Atlanta, GA, that (b) (6), (b) (7)(C), Assistant Field Office Director (AFOD), ICE, at Stewart Detention Center (SDC), Lumpkin, GA, advised that the Georgia Bureau of Investigation (GBI) responded to SDC regarding the death of an inmate. At this time, the detainee, Jean Carlos Jimenez-Joseph (A#: (b) (6), (b) (7)(C)), is believed to have committed suicide by hanging himself in his detention cell. Robeson advised that the GBI was on-scene and processing the involved cell.

The DHS OIG contacted (b) (6) who provided a copy of the ICE Incident Notification Form. (b) (6) also provided contact information for (b) (6), (b) (7)(C), SA, GBI, who was leading the investigation.

Attachment:

(b) (6), (b) (7)(C)

EXHIBIT #2

MEMORANDUM OF ACTIVITY

Type of Activity: Other: Review of GBI Documents

Case Number: I17-ICE-ATL-15215	***Case Title:*** FNU, LNU

On October 25, 2017, (b) (6), (b) , Special Agent (SA), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, completed a review of documents received from (b) (6), (b) (7)(C) , SA, Georgia Bureau of Investigation (GBI), Americus, GA, pertaining to the investigation of the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b)), by the GBI. DHS OIG and the GBI are investigating the death of Jimenez-Joseph which appears to have committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. The GBI is leading the investigation and processed the involved cell. Reference is made to a report dated September 13, 2017, where DHS OIG received a thumb drive from (b) (6), (b) containing investigative documents.

The following items were received from the GBI for review:

- Video surveillance footage on 5/14/17 and 5/15/17
- SDC handheld video response footage
- Miscellaneous cell surveillance footage
- Recorded telephone calls from SDC from March-May 2017
- GBI reports

The investigative documents received are available in the investigative case file. DHS OIG reviewed the items received which yielded the following in sum and substance:

On May 15, 2017, (b) (6), (b) was advised of an apparent suicide at SDC. Upon arrival at SDC (b) (6), (b) interviewed (b) (6), (b) (7)(C) , SDC, Lumpkin, GA and (b) (6), (b) (7) , SDC, Lumpin, GA. At that time, (b) (6), (b) (7)(C) advised that Jimenez-Joseph reported to SDC on March 7, 2017. There were no known disturbances or issues with Jimenez-Joseph. On April 27, 2017, Jimenez-Joseph was placed in a segregation cell for 20 days. An incident report was reviewed which indicated that the segregation was due to Jimenez-Joseph jumping off a 2nd floor walkway down to the 1st floor. Additionally, on May 2, 2017, Jimenez-Joseph, received 3 additional days in confinement for exposing his penis to a SDC nursing staff member.

On May 15, 2017, at approximately 12:45 a.m., (b) (6), (b) (7)(C) was

(b) (6), (b) (7)(C)

completing a round count of Jimenez-Joseph's cell and observed him hanging by his neck from a bed sheet. The other end of the bed sheet was tied to a sprinkler head. Attempts to resuscitate Jimenez-Joseph were made by SDC staff until medical personnel arrived. Stewart County Emergency Medical Technicians (EMT) transported Jimenez-Joseph to Phoebe Sumter Medical Center (PSMC), Americus, GA, where he was pronounced deceased upon arrival.

The SDC staff that assisted (b) (6), were identified as: (b) (6), (b) (7)(C) . Member of the SDC medical staff that responded to the incident were: (b) (6), (b) b) (6), (b) (7)(C)

On May 15, 2017, (b) (6), (b) interviewed (b) (6), (b) (7) advised that in Segregation Unit 7A he was to conduct a round count every 30 minutes. Additionally, there were 4 inmates on a round count of 15 minutes. (b) stated that cell 102 was Jimenez-Joseph's cell, which was located in Unit 7A. (b) stated that on May 15, 2017, at approximately 12:45 a.m, he looked inside cell 102 and overserved Jimenez-Joseph slumped down with a "noose" tied over his neck. (b) then advised of the "Medical Emergency" via radio and went to obtain a "cut-down tool" from the control room. (b) successfully cut the "noose" and he and (b) (6), (b) the first DO on the scene, began CPR until medical staff arrived, which took over attempts to revive Jimenez-Joseph for approximately 10 minutes until EMT's arrived.

On May 15, 2017, (b) (6), (b) (7) , SA, GBI, interviewed Kim (b) (6), (b) (7)(C) , SDC, Lumpin, GA. (b) (6), advised that when Jimenez-Joseph arrived at SDC initial screening was conducted and in which Jimenez-Joseph stated he had a suicidal past, however, never showed any suicidal tendencies while he was at SDC. However, (b) (6), related that Jimenez-Joseph was being treated for a mood condition and was on prescription medications. (b) (6), said the last time she saw Jimenez-Joseph was on May 10, 2017, and related he was normal with no suicidal thoughts.

DHS OIG reviewed numerous detainee interview reports that were conducted by the GBI, none of which provided any information other than a detainee reporting that Jimenez-Joseph would jump up and down in his cell yelling "Julius Caesar." The inmate believed Jimenez-Joseph was having a mental episode.

DHS OIG reviewed an interview report dated May 19, 2017, in which (b) (6), (b) interviewed Andrew Free, Jimenez-Joseph's family attorney. Family members were identified as (b) (6), . Free advised that Jimenez-Joseph had been taking (b) (7) medication and reported that Jimenez-Joseph had been assaulted while incarcerated at SDC. No additional information was provided regarding the alleged assault.

MEMORANDUM OF ACTIVITY

Video surveillance from SDC was reviewed from 10 p.m. on May 14, 2017 through 2 a.m. on May 15, 2017 which encompassing the time frame of the incident. The following persons were identified being present on the video during that time frame:

- Jimenez-Joseph: detainee
- DO's: (b) (6), (b) (7)(C) ; (b) (6), (b) (7)(C)
- (b) (6), (b) (7)(C)
- (b) (6), (b) (7)(C)

A review of the video surveillance yielded the following time-line:

May 14, 2017 – May 15, 2017

10:14 p.m.: (b) 1st check of cell 102 (Jimenez-Joseph's cell).

11:00 p.m.: (b) (6), 1st check of cell 102.

11:02 p.m.: (b) 2nd check of cell 102.

11:25 p.m.: (b) 3rd check of cell 102.

11:58 p.m.: (b) (6), (b) (7) 1st check of cell 102.

12:43 a.m.: (b) 4th check of cell 102. (b) is observed looking through cell window numerous times and talking on a handheld radio. (b) exits Unit 7A. (b) (6), enters Unit 7A.

12:44 a.m.: (b) (6), 2nd check of cell 102 and stands at cell door until (b) re-enters Unit 7A and opens door of cell 102. (b) (6), (b) (7)(C) enter Unit 7A.

12:46 a.m: (b) (6), (b) (7)(C) enter Unit 7A with a stretcher. (b) (6), enters into Unit 7A.

12:46 a.m.- 12:58 a.m.: (b) (6), (b) (7)(C) enter into Unit 7A.

12:59 a.m.: EMT's (b) (6), (b) (7)(C) enter Unit 7A and enter cell 102.

1:14 a.m: Jimenez-Joseph observed being placed on a stretcher. (b) (6), can be observed performing chest compressions.

1:15 a.m – 1:16 a.m.: (b) (6), observed performing chest compressions on stretcher as Jimenez-Joseph was removed from Unit 7A along with SDC staff.

After reviewing the video it was determined that there was a 45 minute span between when (b) (6), (b) conducted his 1st check of cell 102 at 11:58 p.m. and when (b) conducted his 4th check of cell 102 at 12:43 a.m. During that time is when the Jiminez-Joseph incident occurred.

[Agent's Note: Reference is made to a previous reported dated June 30, 2017, where DHS OIG obtained and reviewed ICE policy10-100. The policy review stated that: *in accordance with ICE PBNDS 2.12 Special Management Units, ICE detainees in special management units (SNU) shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly (see Facility policy 9-105 Dry Cell Watches and/or CoreCivic Policy 13-84 Suicide Management).*]

On May 23, 2017, (b) (6), (b) contacted Free which was accompanied by several of Jimenez-Joseph's family members. Family members reported the following: Jimenez-Joseph acted like he had multiple personalities and had previously been admitted to the Mental Crisis Unit in Wake County, NC, on three occasions. On an unknown date in March of 2017, Jimenez-Joseph was assaulted by an unknown Philippine inmate at SDC and wanted to file a police report but had problems getting the incident reported to the police. Jimenez-Joseph tried to commit suicide by jumping off the 2nd story floor at SDC. Jimenez-Joseph attempted suicide two known times in the past, one attempt involved a rope. Jimenez-Joseph stated to a family member during a telephone call he was tired of SDC and tried to kill himself. Jimenez-Joseph also stated he would stay up all night yelling "get me out of here, I am Napoleon." Family members stated they realized Jimenez-Joseph was mentally unbalanced.

The DHS OIG reviewed call logs and transcribed telephone conversations made by Jimenez-Joseph in May of 2017 which yielded the following: Jimenez-Joseph stated in multiple conversations he heard voices; he was diagnosed with schizophrenia, bipolar disorder, psychosis and paranoia and stated he was taking Risperidone for treatment. Jimenez-Joseph stated his voice was hoarse from yelling at the top of his lungs for a long time. Jimenez-Joseph stated he was put in jail for 25 days because he jumped off the 2nd floor balcony and that he tried to hurt himself. He added that he tried to commit suicide because he was sick and tired of being at SDC. Jimenez-Joseph stated he was going to tell the judge about his mental disorder and he needed the family to conduct legal research so he could try to get relief from deportation for a mental disability.

The DHS OIG reviewed information indicating that (b) (6), (b) (7)(C), GBI, Decatur, GA, performed the autopsy related to Jimenez-Joseph in which the cause of death was classified as a hanging and the manner of death was classified as a suicide. (b) (6), (b) noted that the injuries to Jimenez-Joseph were consistent with a self-inflicted hanging. A toxicology report confirmed the presence of Risperidone in Jimenez-Joseph's system.

On July 27, 2017, the GBI stated that upon review of witness statements, crime scene processing, surveillance footage and the autopsy report the case by GBI was closed.

DHS OIG and ICE OPR will commence interviews at SDC to verify the information reported and to investigate any policy violations.

Attachments:

EXHIBIT #3

EXHIBIT #4

EXHIBIT #5

EXHIBIT #6

EXHIBIT #7

EXHIBIT #8

EXHIBIT #9

EXHIBIT #10

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Records Review: SDC Investigation

Case Number: I17-ICE-ATL-15215	***Case Title:*** FNU, LNU

On December 6, 2017, (b) (6), (b) , Special Agent (SAs), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, completed a review of records received from (b) (6), (b) (7)(C) , CoreCivic, Lumpkin, GA. DHS OIG is investigating the events surrounding the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b)), which committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. The Georgia Bureau of Investigation (GBI) led the investigation and processed the involved cell. Reference is made to a report dated October 25, 2017, with the GBI's investigative findings documenting the closure of the investigation in which the cause of death was classified as a hanging and the manner of death was classified as a suicide.

During an interview of (b) (6), (b) (7)(C) on November 2, 2017, records were requested pertaining to the internal investigation conducted by (b) (6), (b) (7)(C) on behalf of CoreCivic into the death of Jimenez-Joseph. (b) (6), (b) (7)(C) indicated at the time of the interview a release for the records needed to be obtained. That approval was obtained and (b) (6), (b) (7)(C) provided the following:

- Investigative Report, Case #: 2017-2505-031-1, 6 pages
- Inmate Information Sheet, 1 page

DHS OIG reviewed the investigative report which outlined a summary and details regarding interviews conducted by (b) (6), (b) (7)(C) of SDC staff members involved in the incident. Specific details can be found in that referenced report.

DHS OIG determined from the report review that (b) (6), (b) (6), (b) (6), (b) (7) SDC, Lumpkin, GA, (who has since been terminated for admitting to falsifying a document pertaining to the amount of rounds conducted in the segregation unit where Jimenez-Joseph was housed) completed "two 5-1C statements."

Additionally, the report stated that (b) (6), (b) (7)(C) , SDC, Lumpkin, GA, (who resigned from SDC after the incident) also completed a written statement to events surrounding the death of Jimenez-Joseph.

(b) (6), (b) (7)(C)

MEMORANDUM OF ACTIVITY

[Agents Note: The SDC Investigative Report referenced above identified written statements from (b) and (b) (6), (b) that were not provided to DHS OIG.DHS OIG requested that (b) (6), (b) (7)(C) provide the statements of (b) and (b) (6), (b) for review.]

Attachments

EXHIBIT #11

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Personal Contact: (b) (6), (b)

Case Number: I17-ICE-ATL-15215	***Case Title:*** FNU, LNU

On November 2, 2017, (b) (6), (b) , Special Agent (SA), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, interviewed (b) (6), (b) (7)(C) , CoreCivic, Lumpkin, GA. DHS OIG is investigating the events surrounding the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b)), which committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. The GBI lead the investigation and processed the involved cell. Reference is made to a report dated October 25, 2017, with the GBI's investigative findings documenting the closure of the investigation in which the cause of death was classified as a hanging and the manner of death was classified as a suicide.

DHS OIG was advised that one CoreCivic employee, (b) (6), (b) (6), Officer, Lumpkin, GA, was fired as a result of this incident. Prior to releasing documents pertaining to his termination, the release of information was approved through human resources.

The following was obtained:

(b) advised that she was present during the termination of (b) (6), (b) indicated that (b) (6), , CoreCivic, Lumkin, GA, and (b) (6), (b) (7)(C) , CoreCivic, Lumpkin, GA, were present as well and advised (b) of his termination. (b) provided a one page document labeled "CoreCivic Facility Employee Problem Solving Notice" which (b) stated was provided to (b) (6),

The document provided was reviewed by DHS OIG which indicated that (b) was issued the noticeon May 14, 2017 for: *Failure to Follow Policy/Procedures and Violating Code of Ethics and Business Conduct.*

A description of the incident stated: *On the evening of May 14 and 15, 2017, Officer* (b) (6), (b) *was assigned to Unit 7A (Restricted Housing Unit) where he failed to make his required 30 minute detainee observation rounds, per CoreCivic policy 10-100 section J Supervisor paragraph 1. Officer* (b) *then falsified document 10-1F, indicating that he made the required observation rounds.*

Attachment
(b) (6), (b) (7)(C)

EXHIBIT #12

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Personal Contact: (b) (6), (b) (7)

Case Number: I17-ICE-ATL-15215	***Case Title:*** FNU, LNU

On November 2, 2017, (b) (6), (b) , Special Agent (SA), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, interviewed (b) (6), (b) (7)(C) , Immigration and Customs Enforcement (ICE), Enforcement and Removal Operations (ERO), Lumpkin, GA. DHS OIG is investigating the events surrounding the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b)), which committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. The GBI lead the investigation and processed the involved cell. Reference is made to a report dated October 25, 2017, with the GBI's investigative findings documenting the closure of the investigation in which the cause of death was classified as a hanging and the manner of death was classified as a suicide.

DHS OIG was advised that (b) (6), lead a policy compliance team on behalf of ICE ERO at SDC and provided the following information:

(b) stated that she led the "Compliance Team" which was a recently formed unit at ICE ERO to review compliance for inspection items. (b) (6), said the unit was formed in February or March of 2017. (b) (6), related that SDC undergoes a variety of inspections from different entities and due to previous inspection results, the unit was formed. (b) (6), did not believe that other ICE ERO detention facilities had similar units.

DHS OIG and (b) (6), reviewed ICE policy labeled 10-100, PBNDS, Special Management Units. The policy states that: *in accordance with ICE PBNDS 2.12 Special Management Units, ICE detainees in special management units (SNU) shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly (see Facility policy 9-105 Dry Cell Watches and/or CoreCivic Policy 13-84 Suicide Management).*

DHS OIG and (b) (6), also reviewed CoreCivic Facility Policy 10-100 regarding Special Management Residents. Section J, pertaining to the supervision of detainees, states: *All inmates/residents of segregation, regardless of status, and restrictive housing, will be personally observed by an officer assigned to the unit twice per hour, but no more than forty (40) minutes apart, on an irregular schedule. Observation will be documented in the 10-1F Confinement Watch Log.*

(b) (6), (b) (7)(C)

[Agent's Note: In the CoreCivic Policy reviewed, special language exists that ICE ERO Policy 10-100, which requires observation of no more than 30 minutes per round is required. The more stringent 30 minute requirement outlined in the ICE ERO policy supersedes the 40 minute CoreCivic Policy.]

(b) (6), possessed limited information on the above captioned policies that DHS OIG previously reviewed but agreed with the assessment that 30 minute rounds are required. (b) (6), did not have any information on ICE suicide management policies, subsequently; the medical and suicide management policies will be outlined in a separate MOA.

Attachments

EXHIBIT #13

EXHIBIT #14

EXHIBIT #15

MEMORANDUM OF ACTIVITY

Type of Activity: Personal Contact: (b) (6), (b)

Case Number: I17-ICE-ATL-15215	***Case Title:*** FNU, LNU

On November 2, 2017, (b) (6), (b) (7)(C), Special Agent (SAs), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, interviewed (b) (6), (b) (6), (b) (6), (b) (7), CoreCivic, Lumpkin, GA. DHS OIG is investigating the events surrounding the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b)), which committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. The GBI lead the investigation and processed the involved cell. Reference is made to a report dated October 25, 2017, with the GBI's investigative findings documenting the closure of the investigation in which the cause of death was classified as a hanging and the manner of death was classified as a suicide. (b) (6), was previously interviewed by (b) (6), CoreCivic, Lumpkin, GA. Reference is made to that report dated May 26, 2017. (b) was terminated from SDC on May 14, 2017, for failing to conduct the required rounds of detainees and then falsifying an internal document, reference is made to that report dated November 2, 2017.

Prior to the interview commencing, agents identified themselves by displaying their credentials and advised (b) the nature of the interview. (b) agreed to speak to DHS OIG and voluntarily provided the following information:

(b) stated he was formerly an officer at SDC for the last six years. (b) added that he began his employment at SDC on the second shift, 2pm -10pm then moved to the third shift, 10pm-6am, which was the shift in which the death of Jimenez-Joseph occurred. (b) indicated he recalled the incident and recalled that (b) (6), (b) (7)(C), CoreCivic, Lumpkin, GA, was the shift supervisor that night and that (b) was assigned to housing unit 7A, which was the segregation unit. (b) advised he was routinely assigned to the segregation unit and had received special training to work in that unit.

(b) stated he recalled leaving unit 7A three times during his shift the night of the incident. (b) said he left one time to get a detainee clothing, left another time to speak to (b) (6), and another time to take a detainee to unit 5. (b) was not sure if leaving the unit was against policy but stated there was one other officer in unit 7A when he left the unit to perform the other duties. (b) added that the other officer present in the unit was a "one on one officer," which has to remain outside a detainee's cell for continuous observation and does not assist with other duties or making rounds.

(b) (6), (b) (7)(C)

(b) advised that he was aware that rounds had to be conducted every 30 minutes; however, he indicated he was trying to cover multiple jobs which resulted in him not being able to make all the required rounds. Resultantly, (b) stated he falsified the required log indicating that he had performed the required rounds when in fact he had not.

(b) was shown a document previously obtained by DHS OIG labeled Confinement Watch Log, 10-1, and dated May 14, 2017. (b) confirmed that the log was the one completed by him the night of the incident and verified that his initials were depicted on the document. According to the document, (b) indicated he performed rounds at "2208, 2236, 2304 and 2332, 0000, 0028 and 0045" (b) admitted to and believed he falsified one of the seven entries notated but could not be sure which entry was false.

(b) stated that he was not ordered by anyone at SDC to falsify the document and stated that he was "just trying to cover himself." (b) indicated that inadequate staffing on his shift put him in the position to have to falsify the document and due to the multiple other duties he performed the night of the incident he could not perform the rounds as required. (b) opined that the segregation unit needs four people at all times and the third shift is the only shift that is inadequately staffed.

[Agent's Note: the segregation staffing model provided by CoreCivic indicated that the first shift (6am-2pm) has one employee in the control room and three on the floor; the second shift (2pm-10pm) has one employee in the control room and two on the floor and the third shift (10pm-6am) has one employee in the control room and one on the floor.]

(b) advised he has complained to management about the inadequate staffing on his shift and was told that the regulations state only one person was needed.

(b) confirmed information pertaining to his response to the incident which corresponded to the GBI investigative report. (b) advised he was still mentally affected by the incident; therefore, DHS OIG limited additional questions pertaining to his response as specific response details are contained in the GBI report.

After the incident, (b) stated he met with (b) (6), (b) (7)(C), CoreCivic, Lumkin, GA, and (b) (6), (b) (7)(C), CoreCivic, Lumpkin, GA, and provided a written statement as to what occurred and was subsequently placed on administrative leave pending the investigation. After the meeting, (b) advised he was interviewed by the GBI. On June 29, 2017, (b) recalled being contacted by CoreCivic and reported to SDC. (b) advised he met with (b) (6), (b) (7) and an unknown human resources employee and was terminated at that time.

(b) was offered the ability to provide a written statement but declined.

Attachments

EXHIBIT #16

MEMORANDUM OF ACTIVITY

Type of Activity: Personal Contact: (b) (6), (b)

Case Number: I17-ICE-ATL-15215	***Case Title:*** FNU, LNU

On November 2, 2017, (b) (6), (b) (7)(C), Special Agent (SAs), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, interviewed (b) (6), (b) (7)(C), CoreCivic, Lumpkin, GA. DHS OIG is investigating the events surrounding the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b) which committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. The Georgia Bureau of Investigation (GBI) lead the investigation and processed the involved cell. Reference is made to a report dated October 25, 2017, with the GBI's investigative findings documenting the closure of the investigation in which the cause of death was classified as a hanging and the manner of death was classified as a suicide. (b) (6), was previously interviewed by the GBI; reference is made to that report dated May 15, 2017.

Prior to the interview commencing, (b) (6), completed INV Form 26, Federal Employee Warning Form (Kalkines) and voluntarily provided the following information:

(b) (6), stated he was an officer at SDC for six years with the last three years as a captain and the three years before that he was a lieutenant. (b) (6), added that he was on the second shift, 2pm - 10pm then moved to the third shift, 10pm-6am, which was the shift in which the death of Jimenez-Joseph occurred. (b) (6), indicated that he was on the third shift for the last four months and that the main difference between the shifts was a lack of movement by detainees during the third shift and the decreased amount of staffing. (b) (6), was asked if any employee had complained about staffing to him on either of his shifts and stated he was not aware of any complaints about staffing that were brought directly to him. However, (b) (6), explained that there have been additional personnel added after the suicide death of Jimenez-Josef, and that an additional officer has been added to third shift.

(b) (6), stated that as a supervisor, employees are required to let him know if they need someone to cover them in a unit. (b) (6), did not recall (b) (6), (b) (6), (b) (6), SDC, Lumpkin, GA, asking him or telling him he needed to leave the unit to do any other jobs or tasking's ((b) was assigned to the segregation unit the night of the suicide). However, as a supervisor, once a shift, he is required to walk around and check to make sure staff is present in assigned units. (b) (6), explained that he has had to counsel employees before for being away from their posts. (b) (6), advised that all officers are issued radios and can call on the radio if they need additional

(b) (6), (b) (7)(C)

personnel.

On the night of the incident (b) (6), recalled hearing a call on the radio from (b) advising of the emergency. At the time of the radio call, (b) (6), was conducting rounds in another unit and came to unit 7A, which was the segregation unit and saw what happened and saw Jimenez-Joseph on the ground. (b) (6), stated that (b) and (b) (6), (b) (7)(C) SDC, Lumpkin, GA, were on-scene. At that time, EMS had already been notified and (b) (6), contacted all staff and gave emergency orders. (b) (6), added that this was the first time he had ever experienced a situation like it.

(b) (6), opined that complacency and a lack of staffing were likely both to blame for the incident occurring. (b) (6), said he checks the log sheets to ensure there are four checks for the assigned period of time per SDC policy but was not aware of any officer falsifying documents or log sheets. (b) (6), stated he was not aware of anyone being disciplined following the incident. (b) (6), added that (b) (6), (b) resigned after the incident for an unknown reason, but possibly for health reasons.

(b) (6), added that at the time of the incident, staffing numbers "were way down and after the incident staffing numbers have come up." (b) (6), explained that to work in segregation forty hours of specific training is required; however, training is not ongoing. (b) (6), advised that a new policy recently came out requiring him to regularly meet with staff.

Attachment

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

ADVICE OF RIGHTS (KALKINES)

You are going to be asked a number of specific questions concerning the performance of your official duties as it relates to:

Inmate Death

Under the provisions of the Inspector General Act, 5 U.S.C.A. App. 3, as amended, you are required to cooperate fully by disclosing complete and accurate information pertaining to matters under OIG review.

You may be subject to disciplinary action, to include termination, for refusing to provide information or answer questions posed by OIG officials if questioned on a matter that may lead only to an administrative action (as distinct from a criminal prosecution).

You are advised that the answers you provide pertaining to the matter presently under investigation, or any information or evidence which is gained by reason of your answers, cannot and will not be used against you in a criminal proceeding, except that you may be subject to criminal prosecution for any false statements made during this interview.

I have read the aforementioned and agree to the terms mentioned therein.

11/2/17
(Date/Time)

Stewart Detention Center
(Location)

(b) (6), (b) (7)(C)
(Printed Name)

(b) (6), (b) (7)(C)
(Signature)

(b) (6), (b) (7)(C)
(Witness Signature)

11/2/17
(Date/Time)

(b) (6), (b) (7)(C)
Name)

ture)

11/2/17
(Date/Time)

EXHIBIT #17

EXHIBIT #18

MEMORANDUM OF ACTIVITY

Type of Activity: Other: Prosecution Summary

Case Number: I17-ICE-ATL-15215	***Case Title:*** (b) (b)

On May 25, 2018, (b) (6), (b) , Special Agent (SA), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, submitted a prosecution summary to (b) (6), (b) , Assistant United States Attorney (AUSA), Unites States Attorneys' Office (USAO), Middle District of GA, Columbus, GA. DHS OIG is investigating the events surrounding the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b) , which committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. DHS OIG learned through investigative interviews conducted at SDC that the falsification of documents had allegedly occurred by an employee or employees at SDC relating to the events surrounding the incident. On November 2, 2017, DHS OIG obtained a confession from (b) (6), (b) (6), (b) (6), (b) (7)(C) , CoreCivic, SDC, who admitted to DHS OIG he falsified a round count document involving Jimenez-Joseph.

DHS OIG submitted a prosecution summary outlying the details of the investigation to date. On May 29, 2019, (b) advised the document had been reviewed and indicted that the prosecution summary was sent to (b) (6), (b) (7)(C) , USAO, Middle District of GA, for additional review and consideration.

The document is internal communication and will remain in the working case file.

(b) (6), (b) (7)(C)

Department of Homeland Security
Office of Inspector General

Prosecution Summary

I17-ICE-ATL-15215
FNU LNU; Lumpkin, GA